Texas Department of Family and Protective Services

Form F-501-2239
Revised October 2019

DFPS Request for Sign Language Interpreting Services

Purpose: Use this form to request and track sign language services provided through the interagency administrative contract (IAC) between DFPS and Health and Human Services Commission (HHSC, formerly DARS).

Overview: Under the process established by the IAC:

1. A DFPS employee contacts a provider directly to request services.
2. The provider bills HHSC at the end of the month in which the services were provided.
3. HHSC bills DFPS for the services, including an administrative fee.

DFPS employees *must* choose providers who are:

- On the list of Communication Services for State Agencies (CSSA) Contractors.
- Located within the DFPS region where the service is needed, if possible.

Directions: The DFPS employee who is requesting services (usually a regional caseworker) fills out the following sections of this form:

- *Information about the DFPS Requester*. The requester must include program activity codes (PAC) for DFPS programs and divisions (DIV) to ensure that the billing is coded correctly.
- *Information about the DFPS Regional Liaison*. To identify the appropriate regional liaison for a program or division, see the list of Regional Liaisons for Translation Services Language Services.
- *Information about the Person Who Needs Services*.
- *Information about the Services*.

If DFPS contacts the service provider by phone to request the services, the DFPS requester also completes the *Service Provider Confirmation* section. If DFPS requests the services by email or fax, the service provider must fill out the *Service Provider Confirmation* section, sign, and respond by phone, email, or fax within ***48 hours of receiving the request.***

After the interpretation services are complete, the interpreter and DFPS requester sign the *Service Validation* section and enter the service time to verify that the service was provided to the client. Signing the form and noting the time are crucial steps for billing reconciliation by the DFPS regional liaison.

This form may be saved to and completed on a mobile device. The signature may be scripted on a tablet or typed with identifying information such as the interpreter's certification number.

Mail or email the completed and signed form to the regional liaison.

INFORMATION ABOUT THE DFPS REQUESTER		
Name:		Date of Request:
DFPS Program or Division:	DIV/PAC* /	Phone Number:
Email:	Fax Number:	

*REQUIRED for payment and/or tracking purposes

INFORMATION ABOUT THE DFPS REGIONAL LIAISON		
Name:	Email:	Phone Number:

INFORMATION ABOUT THE PERSON WHO NEEDS SERVICES

Name:	Age:	Gender:

Is this person a child in the conservatorship of DFPS?

☐ Yes (if you select this option, fill out the rest of this section)

☐ No (if you select this option, move on to the *Information about the Services* section)

Basic information about why the child is in care:

Are the parents deaf or hard of hearing?

What language is used in the biological home?

How does the child communicate? (For example, the child uses sign language to understand what is being said but speaks in response):

INFORMATION ABOUT THE SERVICES			
Service Date:	Start Time (include AM or PM):	Estimated End Time (include AM or PM):	Estimated Number of Service Hours:
Location where services are needed:			
Type of event for which the services are needed (such as during an investigation, placement of a child, or home visit):			
Interpreter certification level requested (see CPS Handbook 1251.61 Obtaining Qualified Interpreters):			
Comments or special instructions that would help the interpreter provide the services or help the provider assign the interpreter:			

SERVICE PROVIDER CONFIRMATION	
Confirm whether the provider will fulfill the request for services from DFPS: ☐ Yes, services are scheduled ☐ No, the provider is unable to provide services	
The provider confirmed scheduling of services with the DFPS requester by (choose one): ☐ Phone ☐ Email ☐ Fax	
Signature or typed name (provider's authorized representative): X	Date Signed:

SERVICE VALIDATION		
Service Date:	Start Time (include AM or PM):	End Time (include AM or PM):
Provider's Contact Phone Number:		
Provider's Certification Level (and certification number if applicable):		
Signature of DFPS Employee: X	Printed Name:	
Signature of Interpreter: X	Printed Name:	
Provider's Name:		